SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Ozark National Life Insurance Company

Product Name: 696	SERFF Tr Num: ONLI-127291635	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 49182
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Jodi Coen	Disposition Date: 07/06/2011
	Date Submitted: 06/29/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 07/06/2011
	State Status Changed: 07/06/2011
Deemer Date:	Created By: Jodi Coen
Submitted By: Jodi Coen	Corresponding Filing Tracking Number:

Filing Description:

This rider form is a portfolio of term products. The product types currently available are:

§ 10 Year Level Premium Term (premiums level for 10 years followed by annually increasing premiums)
§ 20 Year Level Premium Term (premiums level for 20 years or until age 80, whichever occurs first, followed by annually increasing premiums)

The scheduled premiums are level for the specified duration and then increase annually thereafter. Gross premiums are fully guaranteed for all durations.

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

The product will be sold to males and females. The range of issue ages is:

10 Year Level Premium Term 15-69
20 Year Level Premium Term 15-75

The premiums are fully guaranteed. Premiums vary by issue age, duration, gender, underwriting risk class and product. There is no Rider/policy fee. This product is nonparticipating. There is a conversion privilege allowing the insured to switch to any form of whole life or endowment policy then offered by the company. The amount converted is subject to a) a maximum of the amount in force on the term rider at time of conversion and b) the minimum policy requirement of the company at the time of conversion.

A table of premium rates per $1,000 of insurance is included as Appendix A.

Cash Values are calculated as Minimum according to the Standard Nonforfeiture Law. For all issue ages, durations, underwriting classes and products Minimum values are less than $25 per $1,000 of insurance and thus exempt from providing cash values.

Company and Contact

Filing Contact Information

Jodi Coen, Paralegal	jodi.coen@ozark-national.com	
500 E 9th St.	816-842-6300 [Phone] 222 [Ext]	
Kansas City, MO 64106-2627	816-842-7482 [FAX]	

Filing Company Information

Ozark National Life Insurance Company	CoCode: 67393	State of Domicile: Missouri
500 E 9th St	Group Code:	Company Type: life insurer
Kansas City, MO 64106-2627	Group Name:	State ID Number:
(816) 842-6300 ext. [Phone]	FEIN Number: 43-0812448	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	696 SERFF Filing Fee

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ozark National Life Insurance Company	$50.00	06/29/2011	49253863

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/06/2011	07/06/2011

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/06/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	696		Yes

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	696	Initial			AR696 6.29.11.pdf 69610.pdf 69620.pdf

LIFE OF THE OZARKS

SPOUSE PROTECTION RIDER
Providing Insurance for Insured Spouse

The following provisions are part of the Policy to which this Rider is attached, provided a premium for this benefit is shown on the Schedule of the Policy.

WE WILL PAY the amount shown for this Rider on the Schedule to the Beneficiary upon receipt of due proof of the Insured Spouse's death, if such death occurs while this Rider and the Policy are in force.

DEFINITION OF INSURED SPOUSE. The Insured Spouse is the person who is the Insured's spouse on the Application Date and who is designated as Insured Spouse on the Application.

BENEFICIARY. The Beneficiary for insurance under this Rider is the Insured. The Policy sets forth procedures for change in Beneficiary.

CONTINUATION PRIVILEGE. If the Policy, exclusive of Riders, is converted, this Rider may be continued as a part of the new policy.

CONVERSION PRIVILEGE. You or the Insured Spouse may elect to convert this Rider, without evidence of insurability, to a new whole life or endowment policy covering the Insured Spouse, subject to the following:

(1) Proper written application for conversion must be submitted to Us, with payment of the first premium, while this Rider is in force. The Conversion Date and date of the new policy will be the date of such application.

(2) The face amount of the new policy may not exceed the Face Amount of this Rider immediately before the Conversion Date. It may be less, however, subject to Our minimum amount requirements for the new policy.

(3) The new policy will be issued at the Insured Spouse's attained age as of the Conversion Date. The premium will be based on the rates then in use by Us.

(4) The new policy may include riders only with Our consent subject to evidence of insurability as We may require.

REINSTATEMENT. This Rider may be reinstated at the same time the Policy is reinstated, subject to the following:

(1) The Insured Spouse under the reinstated Rider must be insurable. We may ask questions about the health and habits of the Insured Spouse; and

(2) All past due premiums on the Policy and this Rider are paid with interest at the Annual Interest Rate of 6%.

We shall have no liability for a death that occurs after the end of the grace period for a premium in default and before reinstatement.

INCORRECT AGE. If the age of the Insured or Insured Spouse has been misstated, the Termination Date of this Rider shall be those dates according to the correct age.

OWNERSHIP. The Owner of the Policy has control of this Rider.

INCONTESTABILITY. After this Rider has been in force during the lifetime of the Insured Spouse for two years from the Issue Date, or reinstatement, if later, We cannot contest it except for nonpayment of premium.

SUICIDE EXCLUSION. If the Insured Spouse dies by suicide before the end of the two years* after the Policy Date, the benefits payable to the Beneficiary shall then be only the amount of premiums paid before the date of the suicide. This is true whether the Insured Spouse is sane or insane at the time of suicide.

*This exclusion is limited to one year for any policy issued or delivered in the States of Missouri, Colorado and North Dakota.

TERMINATION. This Rider terminates if any of the following occurs:

(1) Expiration of the grace period allowed for any premium in default under the Policy or under this Rider.

(2) Surrender of the Policy or the operation of any Nonforfeiture Option.

(3) The end of the premium paying period of the Policy.

(4) The Policy Anniversary on or after the Insured's or Insured Spouse's ninetieth (90th) birthday.

(5) Thirty (30) days after the Insured's death.

(6) The Date this Rider is converted.

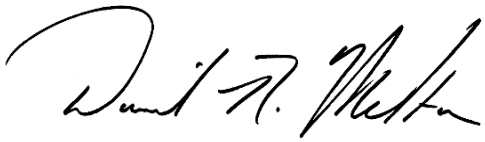
(7) Cancellation by You.

CONSIDERATION. This Rider is issued based on the information in the Application and in consideration of the payment of the premium specified for this Rider in the Schedule. Upon termination of this Rider, the premium shall no longer be payable. We will refund any premium paid for any period after termination.

GENERAL PROVISIONS. This Rider is subject to all provisions and conditions of the Policy which are not inconsistent with this Rider. This Rider will not increase the Loan or Nonforfeiture Values provided by the Policy.

IN WITNESS WHEREOF, We have caused this Rider to be issued as of the Issue Date set forth in the Schedule page of the Policy, unless a different date is shown here.

Chairman and CEO



Secretary

PLAN 696-10 RIDER SCHEDULE

INSURED:	KYMBERLY D SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	SAM SAMPLE	SEX:	FEMALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

FACE AMOUNT/ DEATH BENEFIT	CURRENT ANNUAL PREMIUMS	PERIOD PAYABLE
20,000	16.40	01-10
20,000	82.40	11
20,000	90.60	12
20,000	100.20	13
20,000	110.80	14
20,000	122.80	15
20,000	136.20	16
20,000	151.40	17
20,000	168.40	18
20,000	186.40	19
20,000	205.20	20
20,000	226.80	21
20,000	250.20	22
20,000	275.00	23
20,000	300.80	24
20,000	327.00	25
20,000	354.60	26
20,000	385.00	27
20,000	417.20	28
20,000	451.20	29
20,000	488.60	30
20,000	530.00	31
20,000	575.00	32
20,000	625.20	33
20,000	680.80	34
20,000	741.60	35
20,000	810.00	36
20,000	888.20	37
20,000	973.80	38
20,000	1,067.20	39
20,000	1,170.80	40
20,000	1,284.40	41
20,000	1,409.00	42
20,000	1,547.00	43
20,000	1,697.40	44
20,000	1,862.60	45
20,000	2,067.80	46
20,000	2,319.80	47
20,000	2,586.60	48
20,000	2,866.80	49
20,000	3,179.00	50
20,000	3,495.60	51
20,000	3,869.60	52
20,000	4,331.40	53
20,000	4,818.60	54
20,000	5,303.40	55

CONTINUED (OVER)

PLAN 696-10 RIDER SCHEDULE

INSURED:	KYMBERLY D SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	SAM SAMPLE	SEX:	FEMALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

WAIVER OF PREMIUM	2.40	25 YEARS

PLAN 696-20 RIDER SCHEDULE

INSURED:	KYMBERLY D SAMPLE	POLICY NUMBER:	1067351
AGE:	35	POLICY DATE:	06-27-2011
OWNER:	SAM SAMPLE	SEX:	FEMALE
BENEFICIARY:	AS SHOWN ON THE APPLICATION	PREMIUM CLASS:	NON-TOBACCO

FACE AMOUNT/ DEATH BENEFIT	CURRENT ANNUAL PREMIUMS	PERIOD PAYABLE
20,000	20.40	01-20
20,000	226.80	21
20,000	250.20	22
20,000	275.00	23
20,000	300.80	24
20,000	327.00	25
20,000	354.60	26
20,000	385.00	27
20,000	417.20	28
20,000	451.20	29
20,000	488.60	30
20,000	530.00	31
20,000	575.00	32
20,000	625.20	33
20,000	680.80	34
20,000	741.60	35
20,000	810.00	36
20,000	888.20	37
20,000	973.80	38
20,000	1,067.20	39
20,000	1,170.80	40
20,000	1,284.40	41
20,000	1,409.00	42
20,000	1,547.00	43
20,000	1,697.40	44
20,000	1,862.60	45
20,000	2,067.80	46
20,000	2,319.80	47
20,000	2,586.60	48
20,000	2,866.80	49
20,000	3,179.00	50
20,000	3,495.60	51
20,000	3,869.60	52
20,000	4,331.40	53
20,000	4,818.60	54
20,000	5,303.40	55
WAIVER OF PREMIUM	2.40	25 YEARS

SERFF Tracking Number:	*ONLI-127291635*	*State:*	*Arkansas*
Filing Company:	*Ozark National Life Insurance Company*	*State Tracking Number:*	*49182*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*696*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR696 Flesch Score Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
540 IR 08-AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Life & Annuity - Acturial Memo
Comments:
Attachment:
AR696 Term Statement of Basis signed AR.pdf

CERTIFICATE OF COMPLIANCE

Re: Policy Form No. 696

I have carefully reviewed the above listed form submitted with this Certificate, and, to the best of my knowledge, information and belief, hereby certify the following:

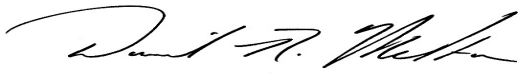
1. The captioned form complies with the applicable statutory and regulatory laws in the state to which this filing is submitted.

2. The captioned form meets or exceeds the legibility and readability requirements in the stats to which this filing is submitted.

3. That the Company complies with Rule and Regulation 19 by providing the consumer with a Life and Health Guaranty Association notice.

4. The captioned forms contain no unusual or controversial provisions.

LIFE OF THE OZARKS



By: _____
David R. Melton, Vice President & General Counsel

Date: June 24, 2011

LIFE INSURANCE APPLICATION TO

LIFE OF THE OZARKS

P.O. Box 219541 Kansas City, MO 64121-9541 (816) 842-6300

For Insurance On Life Of Proposed Insured Named Below

POLICY NUMBER _____

INSURED

USE BLACK INK ONLY - PLEASE PRINT

1. Full name of proposed insured. (**Legal name**)

First Middle Last

State of Birth Birth date (mm/dd/yyyy) Age

Sex: ◯ Male ◯ Female

2. Residence Address

Street

City State Zip

3. Insured's Previous Address

Street

City State Zip

Marital Status:

◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Social Security # ☐☐☐-☐☐-☐☐☐☐

Are you a U.S. Citizen? ◯ Yes ◯ No

Height _____ Weight _____

Home Phone ( ) _____

Bus/Cell Phone ( ) _____

Email Address: _____

4. Driver's License # State Issued

5. Existing Fund Account Numbers

6. a. Proposed Insured's Occupation How Long?

Employer

b. Duties Performed

Location

PLAN INFORMATION

7. Total Annual Premium Mode Premium

Pay Mode: ◯ A ◯ S ◯ Q ◯ M

Pay Code: ◯ ET ◯ DB ◯ SS ◯ GR ◯ FB ◯ PY

8. Plan # of Insurance _____ Base Plan Volume

Rider I _____

Rider II _____

Rider III _____

GR / FB # _____

◯ Tobacco Use ◯ Non-Tobacco

◯ WP ◯ AD ◯ GI ◯ PDD **(See #16)**

9. Special Requests: _____

10. Special Draft Date _____

11. Automatic Premium Loan Clause to be operative? ◯ Yes ◯ No

12. Replacement / Conversion ◯ Yes ◯ No

Prior Policy # _____

OWNER

13. Proposed ownership designation - **Legal name(s)**

◯ Same as above insured

Primary Owner ☐☐☐-☐☐-☐☐☐☐ Owner's Soc. Sec. # Birth Date Relationship

Owner's Mailing Address City State Zip

Contingent Owner ☐☐☐-☐☐-☐☐☐☐ Contingent Owner's Soc. Sec. # Birth Date Relationship

Contingent Owner's Address City State Zip

Agent No. 1 **Agent #** **Agent No. 2** **Agent #**

PRIMARY BENEFICIARIES

14. **Primary** Beneficiary(ies)	**Share %** Leave blank for Equal distribution	**Social Security**	**Birth Date**	**Relationship**
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		

◯ **Additional Primary Beneficiaries Continued on another sheet**

CONTINGENT BENEFICIARIES

15. **Contingent** Beneficiary(ies)	**Share %** Leave blank for Equal distribution	**Social Security**	**Birth Date**	**Relationship**
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		
	%	☐☐☐-☐☐-☐☐☐☐		

◯ **Additional Contingent Beneficiaries Continued on another sheet**

COMPLETE FOR SPOUSE, CPR, PAYOR DEATH / DISABILITY COVERAGE

16. No. of CPR Units _____ Spouse Volume _____ ◯ Tobacco Use ◯ Non-Tobacco

PDD ◯ Yes ◯ No

Proposed Insured	Relationship to Applicant	Date of Birth mm/dd/yyyy	Birthplace (State)	Age	Sex	Height	Weight	Amount of Insurance Now Inforce

Spouse's / Payor's occupation (duties performed, name of employer). | Spouse's Driver's License # | Social Security No. ☐☐☐-☐☐-☐☐☐☐

ADDITIONAL INSURANCE

17. Life Insurance in force on Proposed Insured:

Year Issued	Name of Company	Amount	Amount of Accidental Death

FAMILY HISTORY

18. Family History		Age if Living	Age at Death	State of Health or Cause of Death
Father				
Mother				
Siblings	No. Living			
	No. Dead			

MEDICAL HISTORY
IF ANSWERED YES, GIVE FULL DETAILS - NAMES, AILMENTS, DATES, PHYSICIANS' NAMES, ADDRESSES, ETC.
Identify questions and proposed insured to which details apply

Applicant's Name

First **Middle** **Last**

		Primary Insured		Other Insured	
		Yes	**No**	**Yes**	**No**
19.	Has any proposed insured **ever** been diagnosed, treated, or tested for any of the following:				
	a. Disorder of eyes or ears?	◯	◯	◯	◯
	b. Mental, depression or anxiety disorder?	◯	◯	◯	◯
	c. Seizure disorder, multiple sclerosis, muscular dystrophy, Parkinson's disease, ALS, Alzheimer's disease or other neurological disorder?	◯	◯	◯	◯
	d. Asthma, bronchitis, emphysema, COPD or other chronic respiratory disorder?	◯	◯	◯	◯
	e. High blood pressure, stroke, aneurysm, blood clot, heart murmur, chest pain, heart attack or heart surgery? Other disease or disorder of heart or blood vessels?	◯	◯	◯	◯
	f. Diabetes, tumor, cancer or skin disorder?	◯	◯	◯	◯
	g. Disorder of stomach, intestines, liver, kidney, bladder, prostate or reproductive organs?	◯	◯	◯	◯
	h. Arthritis, disease or disorder of the muscles, bones or back?	◯	◯	◯	◯
	i. Deformity, limited mobility, amputation or paralysis?	◯	◯	◯	◯
	j. Anemia or other disease or disorder of the blood?	◯	◯	◯	◯
	k. Other disease or disorder not listed above?	◯	◯	◯	◯
	l. Is this insurance intended to change or replace any existing life insurance or annuities in any company? (Details below)	◯	◯	◯	◯
20.	Any weight change by more than ten pounds in the last **six months**? If Yes, amount and cause_____	◯	◯	◯	◯
21.	Is any person proposed for insurance:				
	a. Now under treatment or observation ?	◯	◯	◯	◯
	b. List all current medications._____				
22.	In the past **five years**, has any person proposed for insurance:				
	a. received treatment or counseling for the use of alcohol or drugs (prescribed or non-prescribed)?	◯	◯	◯	◯
	b. been advised to receive treatment or counseling for the use of alcohol or drugs (prescribed or non-prescribed)?	◯	◯	◯	◯
23.	In the past **twelve months**, have you used any form of tobacco or tobacco cessation products?	◯	◯	◯	◯
24.	In the past **ten years** has any person proposed for insurance:				
	a. Been told that they had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related condition?	◯	◯	◯	◯
	b. Been advised to obtain tests or treatment in connection with any of these things mentioned in (a) above?	◯	◯	◯	◯
	c. Tested positive for anti-bodies to the "AIDS" (Human T-Cell Lymphotrophic, Type III, TLV-III) virus or Lymphadenopathy Associated Virus (LAV)?	◯	◯	◯	◯
25.	Has any person proposed for insurance ever been disabled or ever requested payment or received a payment for Worker's Compensation, Social Security or other disability income payment?	◯	◯	◯	◯
	Is this person currently disabled or claiming to be disabled?	◯	◯	◯	◯
26.	Within the past **five years** has any proposed insured:				
	a. Been treated by a health care provider or at a health care facility? If YES, provide details.	◯	◯	◯	◯
	b. Had any test, procedure or treatment? If YES, provide details.	◯	◯	◯	◯
	c. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?	◯	◯	◯	◯

MEDICAL HISTORY (Continued)
IF ANSWERED YES, GIVE FULL DETAILS - NAMES, AILMENTS, DATES, PHYSICIANS' NAMES, ADDRESSES, ETC.
Identify questions and proposed insured to which details apply

	Primary Insured		Other Insured	
	Yes	**No**	**Yes**	**No**
27. With regard to any person proposed for insurance:				
a. In the past **five years** have you flown, or do you intend to fly as a pilot, student pilot, or crew member other than for a scheduled commercial airline?	◯	◯	◯	◯
b. In the past **two years**, have you engaged in, or do you intend to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle racing, boat racing, rodeo participation, or scuba or sky diving?	◯	◯	◯	◯
c. Are you now a member of any military service, active or inactive?	◯	◯	◯	◯
d. In the past **ten years**, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?	◯	◯	◯	◯
e. In the past **ten years**, have you been convicted of, or pled guilty or no contest to, a misdemeanor or felony?	◯	◯	◯	◯
f. Are you currently on parole or probation for any misdemeanor or felony?	◯	◯	◯	◯
g. Are there currently any misdemeanor or felony charges pending?	◯	◯	◯	◯
h. In the next **two years**, do you intend to travel or reside outside of the U.S.?	◯	◯	◯	◯

Please provide details for YES answers for Questions 19 - 27.
Include name, date, health care provider or health facility, address and phone number, and outcome.

Proposed Insured	**Ques. #**	

◯ **Additional details Continued on another sheet.**

CERTIFICATION

Each of the undersigned declares they have read the questions and answers above and certifies the answers are complete and true to the best of their knowledge and belief. The following agreements are offered to the Company as a consideration for the insurance. It is agreed that: (1) The Company shall incur no liability under this application until it has been received and approved, a policy has been issued and delivered, and the full first premium specified in the policy has been actually paid to and accepted by the Company while health, habits and occupation of the proposed insureds remain as described in this application, in which case the policy shall be deemed to have taken effect as of the date on which the policy was signed. However, if the full first premium specified in the application on the policy applied for is paid on the date of this application and the Company's receipt is issued to the applicant, then the liability of the Company shall be stated in the receipt and the policy form for which application is made. (2) Only the President, a Vice-President, Secretary, or an Assistant Secretary of the Company can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing. (3) The Company is authorized to amend this application in the space entitled "Home Office Additions or Corrections" and acceptance by the applicant of any policy issued on this application shall constitute a ratification of any such amendments, except no change in the amount of insurance or the amount of the premium or classification of kind of insurance or benefits unless agreed to in writing by the applicant.

FRAUD WARNING

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

ACKNOWLEDGMENT AND AUTHORIZATION

We acknowledge receipt of a statement describing the underwriting procedures and were furnished the notice required by the Fair Credit Reporting Act. We hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any other organization, institution or person that has any record or knowledge of the persons whose signatures appear below (or their children) or their health to give such record or information to the Life of the Ozarks or its reinsurers. A reproduced copy of this Acknowledgment and Authorization shall be as valid as the original. This Authorization shall be valid for 24 months from the date signed.

Monies Received with Application $ _____ For _____ Premium _____

Date and signed at _____ on _____
(City) (State) (Date)

_____ _____
Signature of Spouse (if coverage or **Conversion** applied for) Signature of Applicant

_____
Signature of Owner if other than proposed Insured (Give official capacity if signed on behalf of a corporation)

_____ _____ _____ _____
Witness or Agent Code No. Agent Code No.

Home Office Additions or Corrections

* A A R 0 5 *

CONDITIONAL RECEIPT (DO NOT DETACH UNLESS FULL FIRST PREMIUM IS PAID WITH APPLICATION)

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from _____ the sum of _____ ($ _____) Dollars for the full first premium specified in the application for insurance in Life of the Ozarks which bears the same date as this receipt. The insurance under the policy for which application is made shall be effective on the date of this receipt or the date of completion of the medical examination (if, and when required by the Company), whichever is the later date, if in the opinion of the authorized officers of the Company at its Home Office in Kansas City, Missouri, the Proposed Insured is insurable and acceptable for insurance under the rules and practices of the plan of insurance, for the amount of insurance, and at the premium rate set forth in the application exclusive of any amendments in the space for "Home Office Additions or Corrections." Coverage under this receipt shall expire the earlier of: (i) issuance and delivery of the policy, (ii) rejection of any counter-offer, or (iii) ninety (90) days from the date of this receipt. However, even if the Proposed Insured is so insurable and acceptable, the maximum liability of the Company under this receipt and other insurance in force in this company shall be $100,000 or the amount of said other insurance, whichever is greater. If the Proposed Insured is not so insurable and acceptable, the Company has no liability under this receipt, and the above payment will be returned by the Company's check, upon surrender of this receipt. This receipt shall be void if given for check or draft which is not honored on presentation.

_____ _____
Agent Date

Agents Report and Special Instructions
THIS SECTION MUST BE COMPLETED WHERE APPLICABLE

	YES	NO
28. **STATEMENT OF AGENT REGARDING REPLACEMENT** Do you have knowledge or reason to believe that replacement of existing insurance or annuities may be involved? If Yes, refer to special instructions for your state. If no special instructions, give details here. _____	◯	◯
29. **UNDERWRITING REQUIREMENTS** Was the "Your Insurance Application and How it is Handled" form given to applicant?	◯	◯
30. **If NON-MEDICAL**, these questions MUST be answered before the application can be processed.		
a. Did you see the proposed insured at time of making application? . . . . . (If not, need examination)	◯	◯
b. Do you know of any condition which the proposed insured did not indicate under Medical History?	◯	◯
31. **SETTLEMENT**		
a. Was full premium for mode collected and submitted with the application?	◯	◯
b. If so, was Conditional Receipt given to applicant?	◯	◯
c. Were terms of receipt explained to the applicant?	◯	◯

32. **ALL APPLICANTS**
   a. Previous names and dates of name changes? _____

   b. If married, how much insurance does spouse carry? _____

33. **CHILD APPLICANTS (under age 15)**
   a. Amount of insurance on Father _____ Mother _____

   b. Amount of insurance on brothers and sisters under age 15. _____

OTHER SPECIAL REQUESTS

Date _____ Agent's Signature _____

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Life of the Ozarks, or its reinsurers, may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. www.mib.com

Life of the Ozarks, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.